

AUTHORIZATION TO RELEASE PATIENT-IDENTIFIABLE HEALTH INFORMATION

I, _____, or I, the parent of _____,
whose date of birth is _____, hereby authorize the Calais Regional Hospital to disclose and
discuss my health information as checked below for the following dates: _____

___ discharge summary ___ history/physical ___ operative note ___ pathology report ___ radiology report

___ radiology films ___ lab reports ___ billing information Other _____

___ marketing (if marketing involves direct or indirect remuneration to the hospital from a third party, the individual must be informed as such on this authorization form).

to _____
(name)

Address _____
(street) (city) (state) (zip code)

Purpose: Continued medical diagnosis and treatment. Other reason, if any _____

1. I understand that I may revoke all or part of this authorization at any time by notifying the Health Information Department in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation. The revocation must be signed and dated. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
2. I may refuse to disclose all or some of my health information. Partial information will be labeled.
3. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
4. I am entitled to a copy of this authorization. I may inspect or copy the information to be disclosed.
5. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Department.

If I have been diagnosed or treated for any of the following, I understand that Calais Regional Hospital needs my specific consent to disclose related information. I may cross out any words on this form with which I disagree. In no event will information, if applicable, be disclosed without my specific consent.

1. I (**DO / DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of **alcohol or drug abuse**. Such information may **not** be re-disclosed by the recipient without my specific written consent.
2. I (**DO / DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of **mental health**. I (**DO / DO NOT**) wish to review such information prior to its release. Review must be supervised.
3. I (**DO / DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of **HIV infection, ARC, or AIDS**. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

This authorization expires 90 days from the date signed, and I authorize future disclosures regarding these records to the same individuals or entities during this time period.

Witness

Patient, parent, or legal representative (Identify Relationship)

Date